AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Name:_____ **Date of Birth or ID**#:_____
Mailing Address: _____ **Phone Number**:_____

I am either the patient named above or the patient's legally authorized representative. By signing this form, I authorize:

Hospital/Facility:_____
Address:_____

to use or disclose to: ____ **Lincoln Police Department** and/or ____ **Lancaster County Attorney** the following protected health information: Complete medical records/file regarding treatment received at _____ on, about or after _____; including but not limited to the following: (including reports and notifications pursuant to NEB. Rev. Stat. Sec. 71-501 to Sec. 71-513).

__ Physician's Orders __ Graphs/Charts __ X-Rays __ Other
__ Dictated Reports __ Medication Sheets __ Nurses Notes __ Test Results
__ Progress Notes __ Pathology

The purpose of such use or disclosure is for use in reference to a case being investigated and/or prosecuted in a criminal matter.

Redisclosure of Information - I understand that once information is disclosed pursuant to this authorization that the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 and 164, protecting health information, may not apply to the recipient of the information and, therefore, may not prohibit the recipient from disclosing it. Other laws, however, may prohibit disclosure. Alcohol and/or drug treatment records are protected under the federal regulations governing Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the recipient must be informed that redisclosure is prohibited except as permitted or required by law.

Right to Refuse to Sign this Authorization - I understand that generally the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition my treatment, payment or eligibility for health care benefits on my decision to sign this authorization.

Right to Revoke - I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it.

Right to Inspect - I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form.

Future Treatment – I understand that future treatment or payment will not be conditioned by the signing or not signing of this authorization.

Expiration Date - I understand that unless revoked, this Authorization expires in 180 days from the date it is signed. I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature of Patient/Client:_____
Date:_____ Please Print Name: _____
Signature of Authorized Representative: _____
Date:_____ Please Print Name: _____
Please explain Representative's Authority to act on behalf of the Patient/Client: _____